STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 01 B. WING	06/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/04/12 Facility Number: 010478 Provider Number: 155649 AIM Number: 200197620 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, McCormick's Creek Rehabilitation & Skilled Nursing was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111)	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, resident rooms and spaces open to the corridors. The facility has a capacity for 87 and had a census of 77 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/06/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure there were no impediments to closing doors protecting corridor openings in 1 of 5 smoke compartments. This deficient practice affects staff, visitors and 14 or more residents in the south smoke compartment. Findings include: Based on observation with the maintenance director on 06/04/12 between 1:30 p.m. and 2:30 p.m., the corridor doors to the unoccupied director of nurses office and medical records office were each prevented from closing by a wooden wedge. The	K0018	The wooden wedges have been removed from the door cited which should eliminate any residents from being affected by the alleged deficient practice.Maintenance Director and Administrator toured the facility to inspect for door wedges and removed any present.Door wedges will no longer be available in the facility.Maintenance Director and/or designee will inspect doors 3 times per week for 30 days then 1 time per week for an additional 60 days to assure compliance. Inspections will be reviewed by the Quality Assurance Committee on a Quarterly basis for further recommendations.	07/04/2012

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	maintenance director acknowledged at the time of observations, the doors should not have been prevented from closing. 3.1-19(b)			

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K0021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 2 of 8 doors to hazardous areas, such as the kitchen were held open only by devices which would allow the doors to close upon activation of the fire alarm system. This deficient practice could affect visitors, staff and any residents using the main dining room, located adjacent to the kitchen. Findings include: Based on observation with the maintenance director on 06/04/12 at 1:30 p.m., the self closing doors to the kitchen and a 10 by 12 foot kitchen supply	K0021	The doors to the kitchen were either equipped with a magnetic device to allow the door to automatically close upon activation of the fire alarm or the door wedges removed.All self closing doors to hazardous areas were inspected to assure they remained closed and no door wedges were present.Maintenance Director and/or designee will inspect all doors 3 times per week for 30 days then once per week for 60 days. Results of reviews will be reviewed by Quality Assurance Committe Quarterly for any further recommendations.	07/04/2012

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	storage room were prevented from closing by a wooden wedge. The maintenance director acknowledged the doors were prevented from closing automatically. 3.1-19			

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K0048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a fire plan which included the identification of and evacuation of the smoke compartment, the types of fire extinguishers available, or the use of the K-class fire extinguisher in conjunction with the overhead hood system in the written fire plan for the protection of 77 of 77 residents. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: 1. Use of alarms. 2. Transmission of alarms to fire department. 3. response to alarms. 4. Isolation of fire. 5. Evacuation of immediate area. 6. Evacuation of smoke compartment. 7. Preparation of floors and building for evacuation. 8. Extinguishment of fire.	K0048	The Fire Safety Plan was updated to include "in the event of fire remove residents to an alternative smoke compartment", available fire extinguishers, and the K Class extinguisher in the kitchen.All Fire extinguishers in the facility were inspected for proper inspection dates.The new Policy was reviewed by the Quality Assurance Committee.	07/04/2012

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	This deficient practice affects all residents, staff and visitors in the event of an emergency. Findings include: Based on record review with the maintenance director on 06/04/12 at 11:20 a.m., the Fire Policy & Procedure was incomplete. There was no direction to remove endangered residents to another smoke compartment if indicated. In addition, the fire safety plan did not identify available fire extinguishers and address the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The maintenance director acknowledged at the time of record review, these elements were not addressed in the fire plan. 3.1-19(b)			

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K0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to provide complete sprinkler coverage for 1 of 5 smoke compartments in a one story building of Type V (111) construction. LSC 19.1.6.2 requires one story facilities of Type V (111) construction be provided with complete sprinkler protection. This deficient practice affects residents, staff, and 14 or more residents in the south smoke compartment. Findings include: Based on observation with the maintenance director on 06/04/12 at 2:00 p.m., sprinkler	K0056	An additional fire sprinkler head was installed in the center shower stall in the bathroom in the South smoke compartment.The shower stall was inspected by the Maintenance Director for proper installation.The Fire Protection Contractor will inspect the sprinkler system on a quarterly basis.	07/04/2012

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	protection was not provided for the center shower stall in the main south shower room. The maintenance director acknowledged at the time of observation, the area was not protected by the other sprinklers in the room. 3.1-19(b)			

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K0064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to maintain 1 of 2 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This	K0064	A placard stating the fire extinguishing system shall be used prior to the portable fire extinguisher was placed in the kitchen.The Dietary Supervisor will inspect the placard 5 times per week for 30 days and then once per week for additional 60 days.The Dietary Supervisor will report to the Quality Assurance Committee on a Quarterly basis with any issues for further recommendations.	07/04/2012

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	deficient practice could affect visitors, staff and any residents using the main dining room located adjacent to the kitchen. Findings include: Based on observation with the maintenance director on 06/04/12 at 1:40 p.m., a placard stating the fire protection system shall be activated prior to using the K-class fire extinguisher was not found in the kitchen. The maintenance director said at the time of observation, he was unaware the sign was needed. 3.1-19(b)			

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K0143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfer sites was provided with at least a 45 minute rated door in a fire barrier of 1 hour fire resistive construction to separate the site from any portion of the facility wherein residents are housed. This deficient practice affects staff, visitors and 14 or more residents in the south smoke compartment. Findings include: Based on observation with the maintenance director on 06/04/12 at 1:55 p.m., four 181	K0143	The door manufactorer was contacted and provided documentation that the door meets the requirements of a minimum of 45 minute fire resistance.The maintenance supervisor inspected all doors throughout facility to a minimum 45 minute fire rating.Any future door changes will be reviewed by Quality Rebiew Committee for compliance with proper ratings.	07/04/2012

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	liter liquid oxygen supply containers were stored in a room in the south smoke compartment. The maintenance director confirmed at the time of observation, the room was used for the transfilling of portable oxygen tanks. The door had a label stating the door was "fire resistive" but provided no other evidence of it's resistance rating. The maintenance director could provide nothing to evidence the rating met the minimum 45 minute fire resistance required for the enclosure. 3.1-19(b)			